



**Written Statement of Rosen Bien Galvan & Grunfeld LLP
Before the United States Senate Judiciary Subcommittee on
the Constitution, Civil Rights, and Human Rights**

Hearing on

**Reassessing Solitary Confinement II:
The Human Rights, Fiscal, and Public Safety Consequences**

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Rosen Bien Galvan & Grunfeld LLP (RBGG) appreciates this opportunity to submit testimony to this Subcommittee for its hearing on *Reassessing Solitary Confinement II: The Human Rights, Fiscal, and Public Safety Consequences*. Having worked on behalf of thousands of prisoners who have spent time in solitary confinement, we urge the Subcommittee to take affirmative steps to address the overuse and misuse of solitary confinement in America's correctional facilities, particularly with respect to prisoners with mental illness and disabilities.

Throughout the history of our firm, we have sought to end systemic abuses of prisoners and parolees that harm both our clients and public safety. We have brought about systemic change to reform unconstitutional conditions of confinement, denial of mental health care, unlawful discrimination against persons with physical and mental disabilities, protection of prisoners from sexual assault, and violations of due process. We have represented individuals and large classes of prisoners who have been subjected to a range of abuses and dangerous practices in prisons and jails in California and in other states. For example, RBGG is lead plaintiffs' class counsel in *Coleman v. Brown*, a case in which we represent more than 30,000 mentally ill men and women incarcerated in California's prisons. Over the case's 24-year history, we have advocated for systemic reforms to ensure that mentally ill prisoners receive minimally adequate treatment and are not subjected to substantial and avoidable risks of harm, including psychiatric deterioration and suicide. RBGG was co-lead plaintiffs' counsel in the landmark United States Supreme Court case, *Brown v. Plata/Brown v. Coleman* (2011), in which the Supreme Court found that prison overcrowding was the primary cause of serious and longstanding constitutional violations in California's prisons, and ordered that the State reduce prison crowding to levels at which minimally adequate mental health and medical care can be provided to prisoners.¹

In late 2013, we sought critical reforms to California's use of solitary confinement for prisoners with mental illness during a twelve-day trial before the *Coleman* federal court.² In connection with that proceeding, we gathered a substantial body of evidence on the State's use of segregation – that is, solitary confinement – for the mentally ill prisoner population; the effects of these practices on the mentally ill; and alternatives that are safe, feasible, more humane, and more effective in achieving penological objectives, enhancing public safety and serving the public fisc. The conditions and practices we have seen in California's solitary confinement units provide an important window into the dangers of solitary confinement and the need to chart a new path forward.

We encourage this Subcommittee and all stakeholders to commit to a fundamental transformation in how our correctional institutions respond to prisoners' treatment needs as well as to perceived threats to individual and institutional security. It is time to move away from inhumane and counterproductive practices of isolation and deprivation, in favor of a new paradigm that emphasizes therapeutic and rehabilitative programs, clinically-based intervention, and incentive-driven strategies.

I. THE LESSONS OF COLEMAN: THERE IS AN URGENT NEED TO FUNDAMENTALLY RE-THINK THE USE OF SOLITARY CONFINEMENT, PARTICULARLY FOR THE MENTALLY ILL

The long history of the *Coleman* case yields a critical lesson: the use of harsh solitary confinement conditions for prisoners with mental illness is harmful, counterproductive, and wasteful, and tinkering around the edges of such a system cannot fix the suffering and related problems that it causes. A key part of the remedial process in *Coleman* was the State's decision to try to bring mental health care into solitary confinement rather than to exclude the mentally ill from these dangerous locations. After more than a decade of federal court-supervised efforts, it is time to declare this experiment a failure.

Since the early days of the *Coleman* case, which began in 1990, the use of segregation for prisoners with mental illness has been recognized as “one of the stiffest challenges to [the State’s] creation of a constitutional health care delivery system.”³ Nearly 20 years ago, the *Coleman* court found that the State’s “policies and practices with respect to housing of [mentally ill prisoners] in administrative segregation and in segregated housing units violate the Eighth Amendment[.]”⁴ At that time, the *Coleman* court found that “placing mentally ill inmates in administrative segregation or segregated housing exacerbates the underlying mental illness, induces psychosis, and increases the risk of suicide.”⁵

In 2009, three federal judges presiding over the California prison overcrowding case directed the State to reduce its prison population in order to remedy longstanding constitutional violations regarding mental health and medical care, and specifically noted the “rising number of inmate suicides, particularly in administrative segregation units.”⁶ In 2011, the United States Supreme Court affirmed the three-judge court’s decision, finding that mentally ill “inmates awaiting care may be held for months in administrative segregation, where they endure harsh and isolated conditions and receive only limited mental health services.”⁷

In 2013, the *Coleman* court found that many of the serious solitary confinement-related problems identified in 1995 remain, and indicated several issues that had not been adequately addressed, including the “reduction of risks of decompensation and/or suicide, alternatives to use of administrative segregation placements for non-disciplinary reasons, access to treatment/mitigation of harshness of conditions in the administrative segregation units, suicide prevention, and reduction of lengths of stay in administrative segregation.”⁸ The *Coleman* court also found that these ongoing and unresolved issues meant that prisoners with mental illness continued to face a substantial and unconstitutional risk of harm when placed in California’s segregation units.

Efforts to implement incremental reforms to address the horrible suffering that stems from the State’s solitary confinement system have, sadly, proven to be largely fruitless. For prisoners with serious mental illness, it is simply not possible to provide meaningful or effective treatment in the harsh and utterly anti-therapeutic conditions that define solitary confinement. We have reached a point where stakeholders must fundamentally re-think the

use of solitary confinement in correctional systems in California and elsewhere, particularly with respect to prisoners with mental illness.

II. THE EXTRAORDINARILY HARSH CONDITIONS IN CALIFORNIA’S SOLITARY CONFINEMENT UNITS

All of California’s solitary confinement units share a number of features that constitute severe isolation and sensory deprivation, and deny prisoners normal social interaction.⁹ Prisoners are locked in their cells 22½ to 24 hours per day. The State’s rules permit them to get as little as five hours of out-of-cell exercise per week,¹⁰ and our office regularly receives reports that segregated prisoners in fact receive even less than what the State’s policy requires.¹¹ Prisoners have extremely limited access to phone calls – some get none at all – and have severe limitations placed on their personal property.¹² They eat all meals inside of their cells – the same small space in which they sleep and defecate.¹³ To the limited extent that prisoners are allowed visits by family, they are separated by glass and must communicate over phones.¹⁴ The lack of physical contact means that many prisoners go for years without touching another person with affection. There are no vocational or educational programs or jobs available to prisoners in California’s segregation units. These same punitive rules and conditions apply even in segregation units designed for the most seriously mentally ill as part of the *Coleman* court’s remedial process.

Every time a prisoner is taken out of his solitary confinement cell, he or she is cuffed and escorted by two corrections officers. Every time he or she leaves the housing unit – whether for a medical appointment, a mental health appointment, or exercise – he or she is subject to a full-body strip search. That strip search is repeated when he or she returns to the unit. Whenever mentally ill prisoners are taken out of their unit for treatment, they receive that treatment while standing or sitting inside a small upright metal cage. Not surprisingly, the State Director of Mental Health for the California prison system has testified that, if given the authority, mental health clinicians working in California’s prisons would be very reluctant to allow their patients to be placed in solitary confinement given the risks to their mental health and well-being.¹⁵

California’s system of “segregation” is, by any valid measure, a system of “solitary confinement.” The United States Department of Justice has defined solitary confinement as “the state of being confined to one’s cell for approximately 22 hours per day or more, alone or with other prisoners, that limits contact with others.”¹⁶ This definition is consistent with those offered by scholars on prison conditions, including Dr. Craig Haney, who testified before this Senate Subcommittee on this matter in June 2012.¹⁷

The Indiscriminate Use of Strip Searches. As noted above, all mentally ill prisoners housed in solitary confinement in California are regularly subjected to unclothed strip searches each time they leave their housing unit. This includes each time they go to, and each time they return from, a treatment session or the exercise yard.¹⁸ These blanket strip search policies, applied without regard to individual risk factors or clinical needs, are dehumanizing and counterproductive. The *Coleman* court’s Special Master team of experts

(that regularly monitors conditions and practices inside California prisons) has found that these strip search policies “thwart[] inmate participation” in mental health treatment.¹⁹ A prominent correctional expert testified that the State’s universal strip searches in segregation units are not justified from a custodial perspective, and “may create a deterrent to care for some inmates” who truly need treatment.²⁰ At the recent *Coleman* trial on the State’s solitary confinement practices, the State’s own clinicians along with the State Director of Mental Health admitted that the blanket use of strip searches in segregation settings may be psychologically damaging,²¹ may prevent the delivery of essential mental health treatment,²² and is a policy that should be revisited.²³

Repeated and unnecessary strip searches in solitary confinement units are degrading and damaging to any person, and particularly for prisoners, who studies show have disproportionately suffered from past sexual assault and abuse.²⁴

The Ubiquitous Use of Cages. California relies extensively on upright metal cages to confine segregated prisoners and employs them often and under a wide set of circumstances. We are unaware of any correctional system that uses these cages to the extent seen in California’s prison system, particularly in solitary confinement units.²⁵ But as other jurisdictions experiment with the use of cages, California should serve as a cautionary tale as to the effects of this inhumane practice.

In its *Plata* decision, the United States Supreme Court noted that mentally ill California prisoners may be held “for prolonged periods in telephone-booth sized cages without toilets” and took the rare step of attaching a photograph of one of these cages to the Court’s opinion.²⁶ Yet California’s use of these cages (referred to euphemistically by some as “therapeutic treatment modules”) continues on a massive scale. Mentally ill prisoners in solitary confinement are forced to sit or stand in these cages to receive treatment, or when they report thoughts of self-harm or suicide.²⁷ Psychiatric expert Edward Kaufman, M.D. has noted that these cages “pose a challenge to meaningful therapeutic interactions. To use them for individuals in acute distress, who may be feeling deeply isolated . . . is counter-therapeutic and inhumane.”²⁸ One of California’s own prison experts testified that she had not seen any prisons outside of California that used cages for the delivery of individual mental health treatment.²⁹ The first time she saw them in a California prison, she wrote “cages—terrible hard metal stools. Hard to be in cage for two hours.”³⁰

Our mentally ill clients have expressed how these cages are dehumanizing and anti-therapeutic:

- “I don’t like the cages. I feel like a dog, like an animal—so I don’t usually go out.”³¹
- “Who wants to come out for ‘therapy’ in a cage? You feel non-human.”³²
- “When I am in a cage I feel like an animal.”³³

The sight of isolated prisoners locked in these small cages is truly chilling, and we encourage this Subcommittee to take a stand against their use. Prison systems across the country, such as in Mississippi, Illinois, and Kentucky, have found practical methods to

deliver treatment and other services without the use of cages.³⁴ It is notable that the pervasive use of cages to deliver treatment and programs to prisoners with mental illness or disability also likely violates one of the great Congressional achievements in recent decades, the Americans with Disabilities Act, which requires that public services, programs, and activities (including in correctional settings) be delivered in the *most integrated setting appropriate* to the needs of individuals with disabilities.³⁵ Putting mentally disabled human beings in cages is a clear step in the wrong direction.

Unregulated “Management Cells.” Within California’s solitary confinement units is a second tier of even deeper isolation and deprivation, called the “management cell.”³⁶ These management cells are largely unregulated. They are dark, barren, and sometimes without even a bed for someone to sleep on. They are used to impose additional control and punishment on already isolated prisoners who act out. During recent tours by experts in the *Coleman* case, we found that these cells were occupied by prisoners with mental illness at disproportionately high rates. Dr. Craig Haney described the management cell this way: “[I]t’s hard to imagine anything more distressing and despairing than that cell, even for a healthy person.”³⁷ Prisoners with mental illness were placed in these cells for reasons that include displaying suicidal behavior³⁸ and kicking the cell door out of frustration at the length of time spent in isolation.³⁹

The conditions in management cells are deplorable. But in a system where the solitary confinement mindset is pervasive, their use has become commonplace. In a system where misbehavior can only be met with punishment and isolation, some place must always be created where even more punishment and even more isolation can be imposed. Only a fundamental transformation in how we approach these issues – one that limits the use of solitary confinement and replaces it with more humane alternatives – will free us from this mindset and end these dangerous practices.

III. CALIFORNIA’S USE OF SEGREGATION TO HOUSE PRISONERS WITH MENTAL ILLNESS HAS EXPLODED IN THE LAST DECADE, EVEN AS THE OVERALL PRISON POPULATION HAS DECREASED

Acutely mentally ill prisoners in California are routinely subjected to long terms in solitary confinement. Since 2000, there has been a massive expansion in the use of solitary confinement for prisoners with mental illness, far outpacing any increase in the overall number of mentally ill prisoners during that time period.⁴⁰ In fact, even as California’s prison population has decreased by approximately 40,000 prisoners in the last few years (due in large part to the Supreme Court’s decision in *Brown v. Plata*), the number of mentally ill prisoners in the State’s solitary confinement units has remained steady and, if anything, increased.⁴¹ This accounts for the *Coleman* court’s recent finding that there is an “elevated proportion of inmates in administrative segregation who are mentally ill” in California prisons.⁴²

We presented evidence to the *Coleman* court in December 2013 that the most acutely mentally ill prisoners in outpatient programs are more than twice as likely to be housed in

solitary confinement as compared to other state prisoners.⁴³ Based on the State's own data, at any given moment, *one out of every five prisoners in this category of seriously mentally ill prisoners is held in solitary confinement.*⁴⁴ Such data is enormously alarming and requires urgent action.

Solitary Confinement for Months, Years, and Even Decades. California retains prisoners with mental illness in solitary confinement units for shockingly long periods of time. There are no time limits for how long a California prisoner with mental illness, or any other prisoner, can be kept in solitary confinement. Using the State's data, we found that (as of November 2013) almost 1,500 of the approximately 3,500 mentally ill prisoners in the State's solitary confinement units have spent more than 90 days in solitary confinement. Hundreds of people have spent more than a year in such isolation.⁴⁵ And the reality is likely much worse than what the State's data shows. We discovered that the State systematically underreports lengths of stay in solitary confinement. At the recent *Coleman* trial, the State's witness confirmed that their tracking system "resets the clock" each time mentally ill prisoners transfer institutions or psychologically deteriorate to the point that they need a higher level of mental health care; the system also fails to capture data prior to 2008.⁴⁶ For example, we identified one prisoner with mental illness who had been housed in the Security Housing Unit (SHU) for 23 years, but the State's data reported his length of stay at less than nine (9) months.⁴⁷ We found other prisoners with diagnosed mental illness who had been housed in the SHU for more than a decade. We discovered one mentally ill prisoner who has been sentenced to confinement in the SHU until 2036; he has been in the SHU since August 1999.⁴⁸ Almost half of female prisoners in the SHU have been in isolation for more than a year, with some lengths of stay exceeding 2,000 days.⁴⁹

Federal courts are increasingly recognizing that prolonged segregation harms mentally ill prisoners.⁵⁰ The American Psychiatric Association has found that "[p]rolonged segregation [defined as 3-4 weeks] of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates."⁵¹ The United Nations Special Rapporteur on Torture has called for an end to isolation in solitary confinement units beyond 15 days, and in August 2013 specifically stated that he is "extremely worried about ... the approximately 4,000 prisoners in California who are held in Security Housing Units for indefinite periods or periods of many years, often decades."⁵² Even California's own prison experts have recommended that placement of prisoners with serious mental illness in segregation occur "only when absolutely necessary," and even then, such placements should be "as brief as possible and "as rare as possible."⁵³

But progress in reducing lengths of stay in solitary confinement has largely stalled in jurisdictions like California. As a first step, it is critically important that correctional systems accurately and diligently track the amount of time that prisoners, including the mentally ill, are made to stay in solitary confinement conditions. Systems must also move away from solitary confinement, or at a minimum reduce lengths of stay to a matter of days – *not* weeks, months, years, or decades, as is now too often the practice.

Dangerous Solitary Confinement Placements for “Non-Disciplinary Reasons.”

Another troubling trend is the placement of prisoners, including those with mental illness, in solitary confinement for “non-disciplinary reasons” – in other words, “for no fault of their own.” Hundreds of California prisoners are forced to suffer the extraordinary deprivations of solitary confinement, along with the indignity of repeated strip searching and caging, for reasons that include concerns about their safety on a general population yard or the unavailability of an appropriate non-segregation placement (resulting in what at least one California prison has called “lack of bed” segregation).⁵⁴ A December 2013 report by the State’s Office of the Inspector General found that almost one-third of the 150 female prisoners in the SHU were there for “Refusal to Accept Assigned Housing” or because they had “Enemy/Safety Concerns.”⁵⁵ Eighteen of these women had “served SHU terms in excess of one year.”⁵⁶

To be sure, this misuse and overuse of solitary confinement housing is the product of overcrowding in systems like California’s.⁵⁷ But it also demonstrates a dangerous acceptance of solitary confinement as a legitimate penological practice, used as a means of convenience and expedience in the administration of prisons and jails.

The resulting state of affairs inflicts needless pain and suffering, and puts people at grave risk of harm. California’s data shows that, between 2007 and 2012, approximately half of its prisoners who committed suicide in administrative segregation units (ASU) were in solitary confinement units for “safety” reasons. The State’s suicide prevention coordinator wrote that “placement in ASU of already fearful inmates may only serve to make them even more fearful and anxious, which may precipitate a state of panicked desperation, and the urge to die.”⁵⁸ Other experts have reached the same conclusion.⁵⁹

It is nothing short of tragic that men and women who are placed in solitary confinement for “their own safety” face such harsh isolation conditions that they resort to self-harm and suicide. No person should be forced to choose between his physical health and safety and his mental health and stability.

“Cycling” Between Solitary Confinement and Crisis Care. California’s experience shows that when a prison or jail system becomes committed to the widespread use of solitary confinement and mired in the mindset that supports it, even the most egregious examples of misuse cannot break their dependency on it. These harmful practices persist, even when their use jeopardizes other worthy and agreed-upon goals.

In California, the *Coleman* court and the parties have worked for years to build capacity to provide crisis and inpatient psychiatric care to prisoners who are suffering from acute mental disorders that have led to serious functional disabilities or a risk of self-harm.⁶⁰ Yet California is undermining its own efforts through its continuing widespread use and misuse of solitary confinement. It adheres to a policy that permits suicidal and seriously mentally ill prisoners who have been treated at a crisis or inpatient level of care to be discharged directly to segregation, even if that is where they fell into crisis in the first place. The Statewide Director of Mental Health testified in December 2013 that in the case of a

prisoner who has “been in administrative segregation three times and each time it has resulted in a lengthy stay in a crisis bed or referral to the state hospital,” a prison clinician still has no authority or ability to prevent that prisoner’s return to solitary confinement.⁶¹ Psychiatric experts have documented the avoidable suffering and deaths that have followed from this unconscionable policy.⁶²

IV. THE TRAGIC CONSEQUENCES OF CALIFORNIA’S SOLITARY CONFINEMENT SYSTEM TO HUMAN LIFE AND HEALTH

The tragic effects of solitary confinement are starkly illustrated by the suicide rates in California’s segregation units, particularly among mentally ill prisoners. The *Coleman* court’s suicide expert has reported that the suicide rate in California prisons exceeds national averages, and continues to rise.⁶³ And the suicide rate in California segregation units is even more stunning. The court’s expert has found that the “difference between segregated housing and non-segregated housing with regard to their respective rates of suicides per 100,000 is staggering.”⁶⁴ A recent report by the State acknowledges this fact, noting that segregation units are “high-risk environments for vulnerable inmates.”⁶⁵

California’s suicide data highlight the heightened risks of isolation for mentally ill prisoners. In the past five years, well over half of the suicides in segregation units have taken place among prisoners identified prior to their deaths as mentally ill, a disproportionately high rate.⁶⁶ Addressing the high rates of suicide in segregation units requires effective and pragmatic measures, most urgent among them the removal of the mentally ill from these dangerous settings. Notably, high suicide rates also occur in the segregation units that California has attempted to design to provide mental health treatment.

Segregation unit suicide rates have grave implications for all prisoners in California’s solitary confinement. Even individuals who otherwise suffer no mental illness may deteriorate in the face of extended segregation.⁶⁷ The level of isolation provides scant opportunities for detection of the onset of mental illness. Each year, many of the individuals who take their own lives in California segregation units did not come to the attention of mental health clinicians until after their deaths.

Given what is known about the damaging effects of isolation on human beings, whether or not they have a pre-existing diagnosed mental illness, it is critical that all prisoners housed in solitary confinement be formally evaluated by mental health care providers on a regular basis.⁶⁸ To their credit, states like Washington and Vermont have implemented such policies, while also taking meaningful steps to reduce the number of prisoners in solitary confinement and the amount of time they spend there.⁶⁹ By contrast, California lacks any procedure to formally evaluate the thousands of prisoners in segregation who do not have a mental health diagnosis. As a result, prisoners develop mental illness in segregation units without coming to the attention of custody or on-site nursing staff.⁷⁰ The *Coleman* court recently ordered the State to conduct an assessment of need for inpatient psychiatric care on California’s death row at San Quentin State Prison, which operates like a solitary confinement unit.⁷¹ We have asked the *Coleman* court to order the State to assess all

prisoners who have been housed in isolation for extended periods.⁷² The court’s decision on our request is pending.

V. THE NEGATIVE FISCAL AND OPERATIONAL IMPACTS OF CALIFORNIA’S SOLITARY CONFINEMENT SYSTEM

Solitary confinement units are extraordinarily expensive. Onerous custodial practices drain systemwide staffing resources by requiring large numbers of escort staff for even minor out-of-cell movements. Experts have described segregation units as “costly,” “very expensive . . . to operate,” and “difficult to staff.”⁷³ The State Director of Mental Health admitted that the segregation system’s demands on mental health staff are extremely high, and that reducing the number of mentally ill in isolation would “free up” scarce state resources.⁷⁴

In 2009, California’s Office of the Inspector General concluded that “the annual correctional staff cost of a standard ASU [Administrative Segregation Unit] bed [was] approximately \$14,600 more than the equivalent general population bed.”⁷⁵ At the time, the additional cost (based on the 8,878 ASU beds statewide in 2009) was “nearly \$130 million a year.”⁷⁶ The OIG attributed these additional costs both to the additional staffing required for segregation units and the higher prevalence of single celling in such units.

The costs of segregation units are driven up still further by the psychological harm they inflict. Placing the mentally ill into settings in which they receive *less* and *inferior* mental health treatment has the effect of worsening mental illness. This increases the demands for expensive inpatient psychiatric care resources. Such placements also enhance mentally ill prisoners’ propensity to break institutional rules. The State’s correctional expert has described this phenomenon as a “perfect storm,” in which prisoners with mental illness are unable to comply with disciplinary rules because of their mental illness, get placed in isolation, and then deteriorate in that anti-therapeutic setting, which in turn causes more rule violations and more punitive isolation.⁷⁷

These costs are simply too high, and do not provide a return on investment. California’s experience demonstrates that adequate mental health treatment simply cannot be delivered in segregation units. Scholars, researchers, and knowledgeable mental health professionals—including the State’s own experts—recognize that the harsh conditions created and maintained inside these units are “non-therapeutic.”⁷⁸ Treatment spaces in segregation units are chronically inadequate,⁷⁹ and extremely expensive to build.⁸⁰ Meanwhile, the punitive custodial measures in isolation units discourage prisoners with mental illness from accessing what treatment can be made available.

VI. IMPLICATIONS ON PUBLIC SAFETY

The enormous human and financial costs of California’s solitary confinement system raises the obvious question: Is this system necessary to ensure public safety? The answer by experts who have studied the issue is a resounding “No.” James Austin, a nationally prominent correctional expert who has worked with numerous states (including Colorado,

Georgia, Indiana, Kentucky, Mississippi, New Mexico, New York, and Ohio) and the federal Bureau of Prisons to examine and reform their use of solitary confinement, has stated that the long-term isolation of prisoners simply does not result in reduced levels of violence or fewer violations of prison rules.⁸¹ He has successfully transformed prison systems' solitary confinement systems, imposing time limits in the range of 30-40 days for any term of isolation. He has helped to shift the paradigm towards an incentive-based system to address prisoners' negative behaviors, including clinically driven treatment programs for prisoners with mental illness.⁸² The reforms that he has helped states implement have proven to reduce violence, improve safety, and save money.⁸³

The same applies outside the prison walls. The vast majority of prisoners will serve their time and return to civil society. Those who have been subjected to isolation in prison have been found to have a significantly higher recidivism rate, including a much higher likelihood to commit new violent crimes once released.⁸⁴ In short, solitary confinement is dangerous both inside prisons and in our communities.

VII. RECOMMENDATIONS FOR MOVING FORWARD

Some jurisdictions are finally taking important steps to curb the overuse and misuse of solitary confinement. Just this month, the state of New York announced a set of reforms that will move its prison policies in precisely this direction.⁸⁵ But the sort of paradigm shift that is required to stop the human suffering and fiscal waste that result from continued adherence to segregation systems will require further leadership, including by this Subcommittee. The American Bar Association has developed its *Standards for Criminal Justice, Treatment of Prisoners*, which, among other important provisions, would put strict limits on the amount of time mentally ill prisoners spend in solitary confinement.⁸⁶ The Civil Rights Division of the United States Department of Justice has shown an impressive commitment to using its resources and expertise to investigating some of the worst solitary confinement abuses, particularly as they affect the mentally ill, and to advocating reform.⁸⁷

We urge the Subcommittee to take steps designed to end the long-term isolation of prisoners, and, in the meantime, to help set clear and narrow criteria for the placement of prisoners in isolation. Bright line rules for exclusion and strict time limits are necessary to protect vulnerable populations. Most urgently, it is time to end the use of isolation for the most vulnerable and fragile prisoners, a group that includes juveniles, the mentally ill and the disabled. After decades of litigation aimed at bringing psychiatric care into segregation units, we have reluctantly but firmly reached the conclusion that such efforts are doomed to fail. The mental health and physical safety of prisoners will continue to be jeopardized and undermined, scarce resources that could be spent more wisely will continue to be sacrificed, and public safety will, if anything, be placed at greater risk. Prisoners should not be punished for having a mental illness, and problematic behaviors of prisoners with mental illness are best addressed in a clinically-oriented and operated therapeutic setting. A better path lies ahead of us; we must only choose to take it.

¹ 563 U.S. ___, 131 S. Ct. 1910 (2011).

² Notice of Motion and Motion for Enforcement of Court Orders and Affirmative Relief re: Improper Housing and Treatment of Seriously Mentally Ill Prisoners in Segregation, *Coleman v. Brown* Docket 4580, Case No. Civ. 90-0520 LKK-DAD (“*Coleman*”), May 6, 2014.

³ Special Master’s Recommendations on Administrative Segregation, Involuntary Medications and Identifier Coding, *Coleman* Docket 1008, Jan. 4, 1999 at 1.

⁴ *Coleman v. Wilson*, 912 F. Supp. 1282, 1321 (E.D. Cal. 1995).

⁵ *Coleman v. Wilson*, Case No. CIV S-90-0520 LKK JFM P, 1994 U.S. Dist. LEXIS 20786, at *71-*72, *74 (June 6, 1994) (*Coleman* Docket No. 547) (Findings and Recommendations).

⁶ *Coleman v. Schwarzenegger*, 922 F. Supp. 2d 882, 902 & 930 (E.D. Cal. 2009).

⁷ *Brown v. Plata*, 131 S. Ct. at 1924; *see also id.* at 1933 (“Mentally ill prisoners are housed in administrative segregation while awaiting transfer to scarce mental health treatment beds for appropriate care. One correctional officer indicated that he had kept mentally ill prisoners in segregation for ‘6 months or more.’ . . . Other prisoners awaiting care are held in tiny, phone-booth sized cages. The record documents instances of prisoners committing suicide while awaiting treatment.”).

⁸ *Coleman v. Brown*, 938 F. Supp. 2d 955, 980 (E.D. Cal. 2013).

⁹ Calif. Code Regs. Tit. 15, §§ 3332(f), 3343; CDCR Department Operations Manual § 53130.6; *Coleman* Segregation Trial, Docket 5009, 11/19/13 Hr’g Tr. at 2119:13-2120:24 (C. Haney).

¹⁰ Calif. Code Regs. Tit. 15, § 3343(h).

¹¹ *See also Coleman* Segregation Trial, Docket 5013, 12/4/13 Hr’g Tr. at 2695:4-2696:18 (R. Fischer) & Ex. 2520 (Suicide Report for Prisoner 4, filed under seal), (CSP-Corcoran Security Housing Unit (SHU) prisoner suicide report finding systemic problems with providing adequate hours of exercise yard each week to SHU prisoners).

¹² CDCR Department Operations Manual §§ 54030.7.1, 54030.8, 54030.20.

¹³ *Coleman* Segregation Trial, Docket 5009, 11/19/13 Hr’g Tr. at 2119:13-2120:24 (C. Haney).

¹⁴ Calif. Code Regs. Tit. 15, § 3343(f); CDCR Department Operations Manual §§ 52080.33.5, 54020.22, 53130.6.

¹⁵ *Coleman* Segregation Trial, Docket 5020, 12/19/13 Hr’g Tr. at 3685:2-3686:19 (T. Belavich).

¹⁶ Statement of Interest of the United States of America re Plaintiffs’ Motion for Enforcement of Court Orders and Affirmative Relief re Improper Housing and Treatment of Seriously Mentally Ill Prisoners in Segregation (Letter re “Investigation of the State Correctional Institution at Cresson and Notice of Expanded Investigation”), *Coleman* Docket 4736-1, Aug. 9, 2013 at 5.

¹⁷ *See* Expert Declaration of Craig Haney re CDCR Segregated Housing Units “Declaration re: Segregation of Craig Haney”), *Coleman* Docket 4581, May, 6, 2013 at 3 n.4 (“For perhaps obvious reasons, total and absolute solitary confinement . . . does not exist in prison and never has. Instead, the term is generally used to refer to conditions of extreme (but not total) isolation from others.”); Craig Haney, *The Social Psychology of Isolation: Why Solitary Confinement Is Psychologically Harmful*, Prison Service Journal, 12 (January, 2009), at n.1 (“[S]egregation from the mainstream prisoner population in attached housing units or free-standing facilities where prisoners are involuntarily confined in their cells for upwards of 23 hours a day or more, given only extremely limited or no opportunities for direct and normal social contact with other persons (i.e., contact that is not mediated by bars, restraints, security glass or screens, and the like), and afforded extremely limited if any access to meaningful programming of any kind.”); Hope Metcalf et al., *Administrative Segregation, Degrees of Isolation, and Incarceration: A National Overview of State and Federal Correctional Policies*, Yale Law School, Public Law Working Paper No. 301 (June 2013) (noting that state policies use terms such as “segregation,” “restricted housing,” or “special management,” for programs that commentators refer to as “solitary confinement” or “isolation,” and that these terms generally refer to practices that “entail[] separating inmates from the general population and restricting their participation in everyday activities such as recreation, shared meals, and religious, educational, and other programs,” with housing may be provided in either single or double cells); *Boxed In: The True Cost of Extreme Isolation in New York’s Prisons*, New York Civil Liberties Union (2012) at 34 (“Double-celled prisoners experience the same isolation and idleness, withdrawal and anxiety, anger and depression as do prisoners living alone in the SHU. But double-celled, they must also endure the constant, unabating presence of another man in their personal physical and mental space.”).

¹⁸ Expert Declaration of Edward Kaufman, M.D. (“Declaration of Edward Kaufman”), *Coleman* Docket 4379, Mar. 14, 2013 ¶¶ 98, 101, 121, 163-167; Reply Decl. of Kim Holland in Supp. of Defs.’ Mot. to Terminate, *Coleman* Docket 4438, Mar. 22, 2013 ¶ 10 (CCI); Am. Reply Decl. of Deborah K. Johnson in Supp. of Defs.’ Mot. to Terminate, *Coleman* Docket 4508, Mar. 25, 2013 ¶ 6 (CCWF); Reply Decl. of Connie Gipson in Supp. of Defs.’ Mot. to Terminate, *Coleman* Docket 4430, Mar. 22, 2013 ¶ 19.

¹⁹ Special Master’s 21st Round Monitoring Report, *Coleman* Docket No. 3638, July 31, 2009, at 163.

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- ²⁰ See Expert Declaration of Jeanne Woodford ¶ 56, *Coleman* Docket 4380, Mar. 14, 2013.
- ²¹ *Coleman* Segregation Trial, Docket 5016, 12/11/13 Hr'g Tr. at 3137:5-8 (V. Jordan).
- ²² *Coleman* Segregation Trial, Docket 5013, 12/4/13 Hr'g Tr. at 2671:2-7 (R. Fischer); Docket 5018, 12/13/13 Hr'g Tr. at 3503:13-25 (T. Belavich).
- ²³ *Coleman* Segregation Trial, Docket 5018, 12/13/13 Hr'g Tr. at 3504:15-3505:3 (T. Belavich).
- ²⁴ Janet Warren et al., *Psychiatric Symptoms, History of Victimization, and Violent Behavior Among Incarcerated Female Felons: An American Perspective*, 25 Int'l J. of L. & Psychiatry 129, 129-30, 132 (2002) (discussing prior victimization of incarcerated women and observing that “there is general agreement that female prisoners have endured physical and sexual abuse well beyond that of the general population”).
- ²⁵ See Reply Expert Declaration of James Austin in Support of Plaintiffs’ Motion Regarding Mentally Ill Prisoners in Segregation (“Declaration of James Austin”), *Coleman* Docket 4762, Aug. 23, 2013 ¶¶ 55-57.
- ²⁶ See *Plata*, 131 S. Ct. at 1924 & App’x C.
- ²⁷ See, e.g., Expert Declaration of Pablo Stewart, M.D., *Coleman* Docket 4381, Mar. 14, 2013, Photo Appx. A-O, HH-PP; Expert Declaration of Craig Haney (“Declaration of Craig Haney”), *Coleman* Docket 4378, Mar. 14, 2013, Photo Exs. B, E, Q, CC; Declaration of Edward Kaufman, Photo Exs. C, E.
- ²⁸ Declaration of Edward Kaufman ¶ 86.
- ²⁹ *Coleman* Docket 4424, Am. Ex. 88 to the Decl. of Michael W. Bien in Supp. of Pls.’ Opp. to Defs.’ Mot. to Terminate, Mar. 19, 2013 (Deposition of Dr. Jacqueline Moore at 154:10-155:14).
- ³⁰ *Id.* (Deposition of Dr. Jacqueline Moore at 156:10-156:21).
- ³¹ Declaration of Craig Haney ¶ 83.
- ³² *Id.* ¶ 149.
- ³³ *Id.* ¶ 179.
- ³⁴ See Declaration of James Austin ¶ 56.
- ³⁵ See 42 U.S.C. § 12132; 28 C.F.R. § 35.130(d); see also *Olmstead v. L.C. ex rel Zimring*, 527 U.S. 581, 597 (1999).
- ³⁶ Calif. Code Regs. Tit. 15, §§ 3332(f); CDCR Department Operations Manual § 52080.22.4.
- ³⁷ *Coleman* Segregation Trial, Docket 5009, 11/19/13 Hr'g Tr. at 2194:3-9 (C. Haney) & Trial Exs. 2013 & 2018.
- ³⁸ *Id.* at 2190:16-2194:9 (C. Haney).
- ³⁹ *Id.* at 2195:17-2201:2 (C. Haney).
- ⁴⁰ *Id.* at 2147:4-2149:14 (C. Haney).
- ⁴¹ *Coleman* Segregation Trial Exs. 2035, 2036, 2037, Docket 5009 (11/19/13 Hr'g Tr.).
- ⁴² *Coleman v. Brown*, 938 F. Supp. 2d 955, 980 (E.D. Cal. 2013).
- ⁴³ See Declaration of James Austin at 6 (Table 1) (21% of Enhanced Outpatient Program (EOP) prisoners in segregated housing units vs. 9% of all State prisoners in segregated housing units).
- ⁴⁴ *Id.*
- ⁴⁵ *Coleman* Segregation Trial Ex. 2039, Docket 5009 (11/19/13 Hr'g Tr.).
- ⁴⁶ *Coleman* Segregation Trial, Docket 5013, 12/4/13 Hr'g Tr. at 2600:3-5, 2608:8-19, 2641:14-2642:19 (D. Leidner).
- ⁴⁷ *Coleman* Segregation Trial, Docket 5009, 11/19/13 Hr'g Tr. at 2210:23-2211:22 (C. Haney) & Ex. 2040.
- ⁴⁸ *Coleman* Segregation Trial Exs. 2042, 2043, Docket 5009 (11/19/13 Hr'g Tr.).
- ⁴⁹ *Female Inmates Serving Security Housing Unit Terms in the California Department of Corrections and Rehabilitation*, Office of the Inspector General, State of California, Dec. 2013 at 11, available at <http://www.oig.ca.gov/media/reports/Reports/Reviews/Special%20Review%20-%20Female%20Inmates%20Serving%20Security%20Housing%20Unit%20Terms%20in%20CDCR.pdf>
- ⁵⁰ See, e.g., *Indiana Protection and Advocacy Services Commission, v. Commissioner, Indiana Department Of Correction*, Case No. 1:08-cv- 01317-TWP-MJD, 2012 WL 6738517, *15 (S.D. Ind. Dec. 31, 2012) (finding that “[t]he consensus of opinion in a professional body of literature ... is that segregation is detrimental for people with serious mental illness because it makes their symptoms worse or because, at best, they do not get any better” and that isolation, sensory deprivation, and enforced idleness in segregation can cause decompensation “as soon as 10 days to two weeks after such placement”); *Ashker v. Brown*, Case No. C 09-5796 CW, 2013 WL 1435148, at *5 (N.D. Cal. Apr. 9, 2013) (“[T]he length of confinement cannot be ignored in deciding whether the confinement meets constitutional standards.”) (quoting *Hutto v. Finney*, 437 U.S. 678, 686-87 (1978)); *Madrid v. Gomez*, 889 F. Supp. 1146, 1261–65 (1995) (“[T]he conditions of extreme social isolation and reduced environmental stimulation found in the Pelican Bay SHU will likely inflict some degree of psychological trauma upon most inmates confined there for more than brief periods.”).

⁵¹ American Psychiatric Association, Position Statement on Segregation of Prisoners with Mental Illness, Approved December 2012.

⁵² California Jails: “Solitary confinement can amount to cruel punishment, even torture” - UN rights expert, United Nations Office of the High Commissioner for Human Rights, Aug. 23, 2013, available at <http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=13655&LangID=E>.

⁵³ Clinical Evaluation of California’s Prison Mental Health Services Delivery System, Joel A. Dvoskin, Ph.D., A.B.P.P., Jacqueline M. Moore, R.N. Ph.D. CCHP-A, Charles L. Scott, M.D.; *Coleman* Docket 4275-5, at 23 & 25 of 41.

⁵⁴ Declaration of Craig Haney ¶¶ 143-153; Declaration of Edward Kaufman ¶¶ 96-98, 105, 115-118; Holland Reply Decl. ¶ 6, *Coleman* Docket 4438, Mar. 22, 2013 (“[t]he issue of inmates waiting for transfer to an appropriate bed ... is a statewide one and not just specific to California Correctional Institution”); Gipson Reply Decl. ¶ 19, *Coleman* Docket 4430, Mar. 22, 2013 (“inmates are housed in ASU for non-disciplinary reasons or are housed while waiting for an opening in another unit,” where they are subjected to “unclothed body searches when leaving their cells to go to yard or medical appointments”); Cash Reply Decl. ¶ 11, *Coleman* Docket 4459, Mar. 22, 2013 (explaining that “new intake inmates are sometimes placed in ASU due to lack of bed space” while asserting that “[t]here is no official ‘LOB’ classification at CIM”); Telander Reply Decl. ¶ 6, *Coleman* Docket 4480, Mar. 22, 2013 (explaining that of 90 mentally ill prisoners in segregation unit at one prison, seven had been awaiting transfer for more than 90 days”).

⁵⁵ *Female Inmates Serving Security Housing Unit Terms in the California Department of Corrections and Rehabilitation*, Office of the Inspector General, State of California, Dec. 2013 at 2, available at <http://www.oig.ca.gov/media/reports/Reports/Reviews/Special%20Review%20-%20Female%20Inmates%20Serving%20Security%20Housing%20Unit%20Terms%20in%20CDCR.pdf>

⁵⁶ *Id.*

⁵⁷ *Brown v. Plata*, 131 S. Ct. at 1919.

⁵⁸ *Coleman* Segregation Trial Ex. 2049, Docket No. 5010 (11/20/13 Hr’g Tr.).

⁵⁹ *Coleman* Segregation Trial, Docket 5010, 11/20/13 Hr’g Tr. at 2244:17-2252:7 (C. Haney); H. Sánchez, *Suicide Prevention in Administrative Segregation Units: What is Missing*, Journal of Correctional Health Care, 00(0) 1-8 (2013) (“Prisoners placed in the administrative segregation unit for their safety face similar stressors related to being isolated. They also may experience anxiety, fear, and paranoia associated with the initial safety concerns that led to their placement on this unit.”).

⁶⁰ See, e.g., Order, *Coleman* Docket 1536, July 25, 2003 (order on staffing and beds for inpatient psychiatric programs); Order, *Coleman* Docket 1800, May 2, 2006 (order on State’s long-term plan for provision of inpatient care and mental health crisis beds); Order, *Coleman* Docket 2301, June 28, 2007 (order on Department of Mental Hospital’s staffing to provide care to mentally ill prisoners and state’s plan to provide inpatient care beds for prisoners); Order, *Coleman* Docket 3686, Sept. 24, 2009 (order on State’s plan to build sufficient mental health bed); Order, *Coleman* Docket 3929, Oct. 5, 2010 (order to activate inpatient psychiatric beds for prisoners on an urgent basis); Order, *Coleman* Docket 4214, July 13, 2012 (order on progress in addressing problems with access to inpatient mental health care).

⁶¹ *Coleman* Segregation Trial, Docket 5019, 12/18/13 Hr’g Tr. at 3571:10-3572:4 (T. Belavich).

⁶² *Coleman* Segregation Trial, Docket 5012, 11/22/13 Hr’g Tr. at 2499:22-2504:17 (E. Kaufman) (prisoner repeatedly cycling between the SHU and crisis care); Docket 5014, 12/5/13 Hr’g Tr. at 2822:18-2824:14 & Ex. 2121 (P. Stewart) (mentally ill prisoner committed suicide just days after being transferred directly from the state hospital back to the solitary confinement).

⁶³ Report on Suicides Completed in the CDCR, Jan. 1, 2012-June 30, 2012, *Coleman* Docket 4376, Mar. 13, 2013 at 2, 3.

⁶⁴ *Id.* at 2, 16.

⁶⁵ Decl. of Margot Mendelson in Supp. of Pls.’ Response to Defs.’ Post-Evidentiary Hr’g Br., *Coleman* Docket 5051-1, Ex. 2 (Annual Report of Suicides in the CDCR During 2012).

⁶⁶ Declaration of Michael W. Bien ISO Pls.’ Response to Defs.’ Amended Application and Proposed Order, *Coleman* Docket 5027, Ex. 32; Segregation Trial Exhibits 2800, 2801, 2802, Docket No. 5020 (12/19/13 Hr’g Tr.).

⁶⁷ *Coleman* Segregation Trial, Docket 5010, 11/20/13 Hr’g Tr. at 2306:11-2308:7 (C. Haney).

⁶⁸ American Correctional Association, Standards for Adult Correctional Institutions, 4th ed. (2003), 4-4256.

⁶⁹ See Declaration of James Austin ¶¶ 52-53; 28 V.S.A. § 701a (2012) (Vermont statute setting time limits of 15 and 30 days for segregation of inmates with “serious functional impairment,” including mental illness); Wash. DOC

Policy No. 320.200 (policy that detention in administrative segregation last more than 47 in “extraordinary situations” only).

⁷⁰ Declaration of Craig Haney ¶ 289; H. Sánchez, *Suicide Prevention in Administrative Segregation Units: What is Missing*, Journal of Correctional Health Care at 3, 00(0) 1-8 (2013).

⁷¹ Order, *Coleman* Docket 4951, Dec. 10, 2013 at 25.

⁷² Pls.’ Post-Trial Brief re: Enforcement of Court Orders and Affirmative Relief Regarding Improper Housing and Treatment of Seriously Mentally Ill Prisoners in Segregation, *Coleman* Docket 4985, Jan. 21, 2014 at 8.

⁷³ *Coleman* Segregation Trial, Docket 5016, 12/11/13 Hr’g Tr. at 3035:6-21 (J. Austin).

⁷⁴ *Coleman* Segregation Trial, Docket 5019, 12/18/13 Hr’g Tr. at 3563:1-3564:6 (T. Belavich).

⁷⁵ Special Review: Management of the California Department of Corrections and Rehabilitation’s Administrative Segregation Unit Population, Office of the Inspector General (“OIG Report on CDCR’s ASU Population”), State of California, Jan. 2009, at 22, available at

[http://www.oig.ca.gov/media/reports/ARCHIVE/BOA/Reviews/Management%20of%20the%20California%20Depa
rtment%20of%20Corrections%20and%20Rehabilitation's%20Administrative%20Segregation%20Unit%20Populati
on.pdf](http://www.oig.ca.gov/media/reports/ARCHIVE/BOA/Reviews/Management%20of%20the%20California%20Department%20of%20Corrections%20and%20Rehabilitation's%20Administrative%20Segregation%20Unit%20Population.pdf).

⁷⁶ *Id.*

⁷⁷ *Coleman* Use-of-Force Trial, Docket 5006, 11/5/13 Hr’g Tr. at 1854:10-24 (S. Martin).

⁷⁸ Clinical Evaluation of California’s Prison Mental Health Services Delivery System, Joel A. Dvoskin, Ph.D., A.B.P.P., Jacqueline M. Moore, R.N. Ph.D. CCHP-A, Charles L. Scott, M.D; *Coleman* Docket 4275-5, at 20 of 41.

⁷⁹ See, e.g., Pls.’ Post-Trial Brief re: Enforcement of Court Orders and Affirmative Relief Regarding Improper Housing and Treatment of Seriously Mentally Ill Prisoners in Segregation, *Coleman* Docket 4985, Jan. 21, 2014 at 5-6 (describing treatment spaces in California segregation units).

⁸⁰ See generally OIG Report on CDCR’s ASU Population at 21-22 (describing the costs of administrative segregation units and how CDCR “incurs additional costs as a result of the unnecessary retention of inmates in administrative segregation.”); *Coleman* Segregation Trial, Docket 5017, 12/12/13 Hr’g Tr. at 3237:2-10 (K. Allison) (describing additional steps required to convert a general population unit into an administrative segregation unit, including adding cages).

⁸¹ See Declaration of James Austin ¶¶ 27-29.

⁸² *Id.* ¶¶ 26, 32, 33, 36, 43.

⁸³ *Id.*

⁸⁴ See D. Lovell & C. Johnson, *Felony and violent recidivism among supermax prison inmates in Washington State: A pilot study* (pp. 1-26), Department of Psychosocial & Community Health, University of Washington, Seattle (2003); H. Miller & G. Young, *Prison segregation: administrative detention remedy or mental health problem?* 7 Crim. Behav. and Mental Health 85-94 (1997). See also S. Greene, Clements Murder Suspect Ebel Was Anxious about Walking Free, Documents Show, *The Colorado Independent*, Apr. 26, 2013.

⁸⁵ B. Weiser, New York State in Deal to Limit Solitary Confinement, *N.Y. Times*, Feb. 20, 2014 at A1.

⁸⁶ American Bar Association Criminal Justice Standards on the Treatment of Prisoners (Approved by ABA House of Delegates, Feb. 2010).

⁸⁷ U.S. Department of Justice: Letter: Investigation of the State Correctional Institution at Cresson and Notice of Expanded Investigation, May 31, 2013 (published findings that the Pennsylvania State Correctional Institution at Cresson’s use of isolation on prisoners with serious mental illness violates the Eighth Amendment and Title II of the Americans with Disabilities Act, with notification of expansion of DOJ’s investigation to cover other prisons in the Pennsylvania’s system).